THE COMMONWEALTH OF MASSACHUSETTS
EXECUTIVE OFFICE OF LABOR AND WORKFORCE DEVELOPMENT
DEPARTMENT OF UNEMPLOYMENT ASSISTANCE

THE MEDICAL SECURITY PROGRAM

P.O. Box 146758
Boston, MA 02114-0020

Enrollee/Member's Authorization for Release of Information

Please note:

The enrollee/member named below should be the person signing this authorization and requesting the release of information. If the enrollee/member is a minor, a parent or legal guardian must sign. If the enrollee/member is unable to sign for any other reason, a legal representative must sign the authorization and submit documentation to verify the authority to sign.

Enrollee/member's name:_____

Enrollee/member's SSN#: _____ Date of Birth: _____

Address: _____

_____

Daytime Phone Number:_____

I authorize the Massachusetts Department of Unemployment Assistance Medical Security Program (DUA/MSP), to disclose claims and medical information in its files as follows:

Please circle one answer for each option listed (circle "No" if not applicable)

I authorize release...		*of these records*
Yes ☐	No ☐	Application status
Yes ☐	No ☐	Enrollment information
Yes ☐	No ☐	Claims and information related to payment
Yes ☐	No ☐	Claims and medical information listed here (please describe in detail):

_____
_____
_____

Name of person or entity to receive information:_____
Address:_____
_____

This authorization is valid for one year from the date I sign it. It is completed at my own request and is not a condition of enrollment or benefits. I may revoke this authorization at any time by notifying DUA/MSP in writing. I understand that a revocation will not apply to information already released while this authorization was in effect. I understand that once information has been released according to these instructions, DUA/MSP will not be able to limit the recipient's use or disclosure of the information, and privacy laws may no longer protect the information. I may receive a copy of this authorization and agree that a photocopy is as valid as the original.

Signature:_____ Print name:_____

Date:_____

If not the enrollee/member, please state your relationship to the enrollee/member (for example, "parent") here: _____